# WORKLOAD STANDARDIZATION AND THE MHS PROVIDER

TRICARE MANAGEMENT ACTIVITY
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## Benefits from Accurate and Complete Reporting

Automation opens doors for many improvements in health care – but only if the computer has the data necessary to provide the support. Examples of benefits attainable only through the capture of complete encounter data include:

- the identification of best practices
- epidemiological studies of disease incidence in populations
- outcome studies that assess efficacy of various procedures
- management of referral networks and referring practices for high quality, cost effective care
- ensuring the availability of resources in support of physician processes.

There are also on the horizon a host of secondary benefits from the capture of detailed encounter data. These include:

- increased third party collections from insurers who are more familiar with procedure-based billing
- higher capitated payments from Medicare, both in the demonstration and nationwide, if the demonstration is deemed successful
- fairer settlements with TRICARE support contractors for services provided to beneficiaries who are not enrolled or are enrolled with the contractor as PCM in the next round of TRICARE contracts
- future elimination of provider self-reporting of labor hours as the method to allocate provider costs among health care work centers
- eventual elimination of the requirement for manual paper entries in voluminous patient records.

Realizing these benefits depends on the accurate and complete capture of encounter data. Each instance of a provider service that goes unreported is analogous to civilian "lost charges." This lessens our ability to provide knowledgeable quality care for the patient in the future and to provide provider feedback on best practices and outcome-based assessments.

## OVERVIEW OF CHANGES FROM FY 1999

Many providers at many facilities will not encounter any requirement for new data collection because of the workload standardization effort. However, it will be more important to complete the ADS encounter forms (bubble sheets) that were already required in FY 1999. This booklet outlines changes in how data are to be captured for various situations for some providers. In general, a provider should review the appropriate section of this booklet if he/she . . .

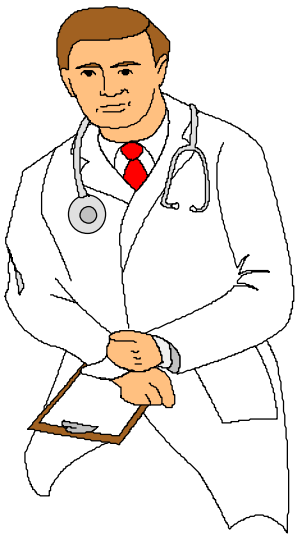
- Participates in telemedicine, other than for ancillaries.
- Provides care away from the MTF, either in the patient's home, or at another treatment facility that is not charged for the provider's time.
- Directly provides medications or high cost materials to patients. (This does not include writing prescriptions or orders for these items.)
- Provides care to or writes admission orders for inpatients.
- Is a non-physician acting as an independent provider, such as an audiologist or nurse-practitioner.

There are three general types of changes for FY 2000. One is the routine recording of provider services delivered to inpatients, using ADS. The second is the insertion of special codes onto certain encounter records to identify when a special occasion has occurred. The final change provides the ability to identify services to inpatients not meeting InterQual standards for acute hospitalization; here referred to as "non-acute hospital admissions." This booklet contains the information needed by a provider for correct capture of workload in any of the possible situations. Few MHS providers will encounter all of the situations described in this booklet.

## RECORDING ENCOUNTERS

Current policy calls for recording ambulatory encounters using the ADS encounter form, either as a bubble sheet or direct computer screen entry at some sites. The new workload standardization guidance does not alter this requirement, although it becomes much more important to use the correct Current Procedural Terminology (CPT) codes for procedures performed and International Classification of Disease (ICD-9-CM) codes for diagnoses.

This section identifies special situations in which provider-patient encounters can occur, and how the ADS encounter form should be completed in these situations differently than in less routine situations. New entries have been designed for use on an interim basis to "tag" encounters for these special situations until ADS encounter forms and supporting information systems can be modified for a permanent solution.



*For a given encounter,*
*how do I ensure **my workload has been captured**?*

There are three essential elements for workload to be captured accurately.

First, your specialty as listed in a table in CHCS must reflect correctly your highest qualified credentialed level. This table is called the Provider Table and is maintained at your MTF. It should list you with an appropriate and specific skill level. For example, if you are a board-certified orthopedic surgeon, your entry in the table should not be "orthopedics" or "resident" or even "general medical officer". It should be "Orthopedic Surgeon". This check and/or correction is done only once and then your correct skill level will be automatically associated with all ADS encounter forms you complete.

Second, your CHCS provider identification number must be on each of your ADS encounter forms. If the encounter was generated from CHCS using the normal appointment process for you, this will already be filled in correctly. Some clinics book appointments for "generic" providers that are not specific individuals, so if this is the case, you need to replace that provider ID number with your own on the ADS encounter form.

Third, the actual procedures you perform during the encounter need to be recorded as CPT codes on the ADS encounter form. ADS requires one and only one Evaluation and Management (E&M) CPT code as well as any appropriate procedural CPT codes. If the encounter is so complex that there are more procedures performed than there is room to record on the ADS encounter form, the most major procedures should be the ones recorded.

*For a given encounter,*
*how do I record a* ***home health visit****?*

There are a variety of reasons to record home health visits, including that they tend to be more expensive due to travel time and related costs, and because the provider must usually work unassisted by other staff.

To "tag" a home health visit as such, two entries are made on the ADS encounter form in the fields designated for the first "Additional Provider":

| Provider ID | Provider Role |
|---|---|
| 000-00-0011 | Paraprofessional |

If there is a secondary provider involved in the encounter, his/her identification and role are entered in the second "Additional Provider" field that is still available.

If there are additional secondary providers involved in the encounter, they will not be listed on the ADS encounter form. Thus, it is important that the one secondary provider that is listed (in the second "Additional Provider" fields) be the highest skilled (most costly) of all the secondary providers.

*For a given encounter,*
*how do I record initiating a **telemedicine consult**?*

Providers who initiate telemedicine consults generally perform the same amount of work and incur the same provider and facility workload as if there was no distant provider involved. However, it is still helpful to clearly label these encounters because it improves our ability to identify best practices, determine resourcing requirements for communications, and validate which facilities distant providers are serving.

To "tag" an encounter as one in which a telemedicine consult originated, two entries are made on the ADS encounter form in the fields designated for the first "Additional Provider":

| Provider ID | Provider Role |
|---|---|
| 000-00-0033 | Paraprofessional |

If there is a secondary provider involved in the encounter, his/her identification and role are entered in the second "Additional Provider" field that is still available.

If there are additional secondary providers involved in the encounter, they will not be listed on the ADS encounter form. Thus, it is important that the one secondary provider that is listed (in the second "Additional Provider" fields) be the highest skilled (most costly) of all the secondary providers.

*For a given encounter,*
*how do I record* ***performing*** *a* ***telemedicine consult****?*

Providers who perform telemedicine consults incur the diagnostic (provider) workload but they and their facility are spared the workload of data collection / testing of the patient. It is important to identify these encounters to capture the provider workload in support of distant facilities.

To "tag" an encounter as one in which a telemedicine consult was performed for a distant patient & provider, two entries are made on the ADS encounter form in the fields designated for the first "Additional Provider":

| Provider ID | Provider Role |
|---|---|
| 000-00-0022 | Paraprofessional |

If there is a secondary provider involved in the local consultant service, his/her identification and role are entered in the second "Additional Provider" field that is still available.

*For a given encounter, how do I record work done*
***at some other hospital (or treatment facility)?***

IMPORTANT!! Provider workload needs to be captured in the same organization (and work center) which bears the provider's salary costs. If a provider is officially *loaned* to another facility (which *borrows* the provider), the financial systems should receive this information and the provider simply completes normal ADS encounter forms at the facility where he/she performs the work.

The process described below applies only when the provider is NOT loaned to the other facility. Examples include when a provider takes his/her patient to a nearby military facility because of a space or equipment requirement, or performs a service for his/her patient at a civilian hospital (under *external resource sharing or other agreements*).

**The ADS encounter form to record this work must be entered into ADS at the provider's hospital**.

To "tag" an encounter as one where the provider worked at an external facility, two entries are made on the ADS encounter form in the fields designated for the first "Additional Provider":

| Provider ID | Provider Role |
|---|---|
| 000-00-0044 | Paraprofessional |

Note: A second ADS encounter form is needed if the external facility is military, and the provider may be asked for help in completing this form as well. It is described in the following paragraphs.

If the external hospital is military, it also needs an ADS encounter form to ensure quality clinical data in its computer, as well as recognize the facility workload of supporting the provider. **The ADS encounter form to record the workload for the external facility must be entered into ADS at the external military facility.**

To "tag" a visit as one where the primary provider came from another facility without being "borrowed", two entries are made on the ADS encounter form in the fields designated for the first "Additional Provider":

| Provider ID | Provider Role |
|---|---|
| 000-00-0055 | Paraprofessional |

If there is a secondary provider involved in the encounter, his/her identification and role are entered in the second "Additional Provider" field that is still available.

If there are additional true secondary providers involved in the encounter, they will not be listed on the ADS encounter form. Thus, it is important that the one true additional provider that is listed (in the second "Additional Provider" fields) be the highest skilled (most costly) of all the secondary providers.

*For a given encounter, how do I record giving patients* ***medications or high cost materials****?*

Military hospitals typically rely on pharmaceutical records to track specific medications to patients. However, if a provider dispenses the medications directly to the patient, no pharmacy records are created. Thus, if a medication lot was found to be tainted or a subsequent adverse reaction occurred, the computer does not have the data to either identify the medication, given the patient name, or to identify which patients received a medication.
The solution to this is to record the CPT or HCFA Common Procedure Code (HCPCS) codes of the medications on the ADS encounter form. For most clinical services, there are so few directly dispensed medications that it is a small one-time task to look up the correct codes for these medications and have them readily available for the ADS encounter forms. These codes are then entered in the normal CPT code fields of the ADS encounter forms.

There is also increasing emphasis on tracking high cost durable medical equipment (DME) and other high cost items given to patients. For most clinical services, such issues occur rarely or not at all. For clinics or services that do issue high cost items such as hearing aids (using $200 as a guide to high cost), the issue can be recorded on an ADS encounter form using the appropriate HCPCS code in the CPT code field.

*For a given encounter,*
*how do I record* ***non-physician independent provider services****?*

You may be an independent provider who is not a physician, such as an audiologist, optometrist, physician's assistant, or nurse-practitioner. For this section, "independent" means only that you deliver significant health care services at patient encounters as the most-skilled provider present or overseeing that encounter. Other examples include encounters solely for treatments by physical therapists and occupational therapists, and post-operative assessments and removal of sutures by a nurse.

In general, a non-physician provider records the encounter in the same way as a physician provider would record it. This includes entering the provider's Provider ID, the CPT codes for the procedures performed, a single E&M code and the ICD9-CM code, and flagging the encounter as described elsewhere in this booklet if it was, for example, a home health visit by a nurse.

For some types of care that are rarely or never performed by physicians, there may be no existing CPT code describing the procedure. Examples include dentistry, audiology, and optometry. For these services, the appropriate HCPCS codes should be entered in the CPT fields of the ADS encounter form.

*For a given encounter,*
*how do I record* ***provider services for inpatients****?*

A provider should record on an ADS encounter form those inpatient encounters that were sufficiently significant to merit a provider note in the patient's medical record. (This includes care delivered to inpatients for care categories less demanding than acute hospital care, as described in the next section of this booklet.) In general, the only difference between recording these inpatient encounters and recording an outpatient encounter is that the ADS encounter form is marked as "inpatient" in the appropriate field. However, inpatient stays produce several situations not typically arising in ambulatory care.

- *Routine ward services* do not call for ADS encounter forms. Typical nursing care, nutrition, and similar services commonly associated with staying in a ward do not get recorded on ADS encounter forms.
- *Morning rounds*, when accomplished by a provider who annotates the medical record, should be recorded on an ADS encounter form. But *grand rounds*, or rounds where additional providers are present, do not call for any additional ADS encounter forms.
- *Continuous* or *near-continuous care*, such as an ICU physician may provide to a critically ill patient, should be recorded. A single ADS encounter form can record multiple procedures over a period of time with a new form started when a new day begins. If additional providers participate, they can be recorded in the "additional provider" fields of the same ADS encounter form.
- *Care for inpatients at another facility*, provided by a physician whose labor is not "loaned" to that other facility, is as described in the section of this booklet on *work at some other hospital*.
- Providers of *ancillary services* should not document their services using ADS encounter forms.

Recording these inpatient encounters is much easier when a preprinted ADS encounter form is kept available near the patient (such as in the inpatient record).

## RECORDING NON-ACUTE HOSPITAL ADMISSIONS

DoD hospitals may have inpatients that would not satisfy InterQual standards for admission to an acute care hospital. Examples include both patients who have partially recovered but are not sufficiently well to go back to a barracks or home environment, as well as patients who have experienced procedures, illnesses, or injuries (such as tooth extractions at some training center installations) not severe enough to require hospitalization but where local policy does not permit a return to the barracks.

Generally, the workload standardization for FY 2000 alters very little of the administrative process for providers for these situations. Those minor changes are described in this section.

*For patients not requiring acute hospitalization, how do I admit a patient?*

When a provider decides to admit a patient who is not sufficiently ill to require acute hospitalization yet conforms with the local policy about the appropriateness of such an admission, the primary additional action required of the provider is to determine the level of care the patient requires. This section first describes the care categories that match this requirement, and then describes the small process alterations required for these patients.

## Care Categories

*Skilled Nursing Care* is comprehensive inpatient care designed for someone who has an illness, injury, or exacerbation of a disease process. It is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a person's underlying long term care condition and overall situation. However, patients in this category do not meet the InterQual standards for admission to acute hospitals.

*Minimal Care* is minimal services to patients who require some level of nursing care and periodic evaluation by a physician but who would not meet the criteria for admission to SNF.

*Hospice Care* is for the palliation or management of a terminal illness (a medical prognosis of life expectancy of 6 months or less) and related conditions. The following are included as hospice services: nursing care; medical social services; physician services; counseling services; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Note that *self-care* – people who do not require trained medical personnel services – are not appropriate for admission at any time.

Procedure

Admission of these patients follows normal inpatient processes with one exception: the orders for admission must clearly state that it is for one of the care categories just described, rather than acute care hospitalization. This enables the admitting clerk to record one of three admitting services (AZA for hospice, AZB for SNF, and AZC for Minimal) into the inpatient record to identify it as that kind of episode.

If a patient changes status within the non-hospital setting (such as a SNF care level patient converting to a hospice care level patient), no discharge is required, and the provider need only record orders for the transfer to the appropriate care level.

If a patient deteriorates and requires acute hospitalization, this non-hospital stay should be terminated with a discharge (discharge type is to a military hospital) followed by a subsequent admission to the hospital. The admitting physician would write normal admission orders for this purpose.

*How do I retain an acute hospital inpatient who is well enough to be discharged but not well enough to go home?*

A provider may decide to retain a patient at the MTF, even though the patient has recovered sufficiently during the episode that he/she no longer requires acute care hospitalization. Examples include patients who might cope well in a hospice, in a skilled nursing facility, or even in a home environment with home health agency support, but who are not well enough to return to the barracks or their home, and for which local policy is not to send the patients to a civilian non-hospital institution. If such patients are retained as hospital inpatients, they may be overtreated, and analysis of best practices and provider performance will erroneously show poor outcomes and inefficient care. To avoid this, the patient is discharged from the hospital with an appropriate discharge status (such as discharged to skilled nursing facility), and the provider completes the inpatient record. At the same time, the provider orders admission to inpatient status as a non-acute hospital patient as described in the preceding section of this booklet, which also provides more complete descriptions of the care categories.

For continuity of care, the hospital in-patient record should remain with the patient until final discharge from the non-acute hospital stay.

If a patient changes status within the non-hospital setting (such as a SNF care level patient converting to a hospice care level patient), no discharge is required, and the provider need only record orders for the transfer to the appropriate care level.

If a patient deteriorates and requires acute hospitalization, this non-hospital stay should be terminated with a discharge (discharge type is to an MTF hospital) followed by a subsequent admission to the hospital. The admitting physician would write normal admission orders for this purpose.